MILESTONES
PEDIATRIC DENTISTRY

Patient Information

Child's name:

first_____middle_____last_____

Gender M F Prefers to be called_____ Birthdate _____/_____/_____

Address & Contact Info:

Street_____city_____state_____zip_____

Phone_____Alternate 1_____Altrnate 2_____

Family's primary email addres _____@_____*Future appointments may be confirmed via email. Please inform the staff if you do not wish to receive these emails.

Whom may we thank for referral?

Internet search ____ Insurance ____ Yellow pages____ Advertisement _____

Relative/Friend_____ Pediatrician_____ Dentist_____

Other_____

Parent/Guardian information:

Mother's name_____
Date of birth ____/____/_____
SSN _____---_____---_____
Occupation_____

Father's name_____
Date of birth ____/____/_____
SSN _____---_____---_____
Occupation_____

Address (if different from above)_____

Dental insurance infomation:

Primary dental insurance plan name _____Insurance phone # _____

Subscriber's name _____ Relationship to patient _____ Subscriber's SSN or member/ policy ID # _____ Member DOB ____/____/_____Group # _____ Subscriber's Employer_____

Secondary dental insurance plan name _____ Insurance phone# _____

Subscriber's name _____ Relationship to patient _____ Subscriber's SSN or member/policy ID # _____ Member DOB _____

Group # _____ Subscriber's Employer_____

Milestones Pediatric Dentistry, PC
Dr. Carolyn Lubrano | 696 Newport Avenue, Attleboro MA 02703 | (508) 399-8200
info@MilestonesPediatricDentistry.com | www.MilestonesPediatricDentistry.com

Dental History:

Is this your child's first visit to a dentist? Y / N

If no, former dentist_____

Date of last dental visit_____ Reason for visit? _____

How many times a day is your child brushing? 0 | 1 | 2 | 3+

Does he/she floss? Y / N

Does he/she take fluoride in any of these forms? Tablets | Drops | Toothpaste | Rinse/Gel | Bottled H20 | Other

Have any current complaint of dental pain? Y / N

If yes, please explain: _____

Does your child have a history of:

___Thumb/finger sucking ___Pacifier ___Bottle feeding ___Breastfeeding ___Sippy cup

___Speech issues ___Bleeding/Sore gums ___Mouth breathing ___Bad breath ___Grinding/clenching ___

Abscess/infection ___Nail biting ___Other _____

Medical History:

Pediatrician _____ Phone_____

Address/town _____ Date of last physical _____

Please list the medications your child is currently taking: _____

_____

Has your child ever been hospitalized or had surgery? Y / N

If yes, please explain: _____

_____

Does your child have allergies to ___Penicillin/Amoxicillin ___Sulfa ___ Latex ___ Other

Please specify all known allergies including food and environmental allergies: _____

_____

Has your child had any of the following? Please check all that apply:

AIDS/HIV _ Cerebal Palsy _ Jaundice (severe) _Seizures _ ADHD/ADD _ Convulsions/Epilepsy _

Kidney disease _Sinus problems _ Anemia _Diabetes _Learning disablity _ Speech delay _ Asthma _

Ear infections (chronic) _Liver disease _ Stomach/GI _ Autism/PDD/Spectrum _Genetric disorder _

Measles problems _Birth defect _Head injury _ Mononucleosis _Tuberculosis _Bleeding disorder _

Hearing disability _ Mumps _Tumor _Blood transfusion _Heart mumur _Psychiatric care _

Vision problems _Bone disorder _ Heart problems _ Radiation therapy _Bronchitis _Hepatitis _

Respiratory issues _Cancer _High blood pressure _ Rheumatic fever _ Other: _____

_____

To the best of my knowledge, all of the preceding answers and information are true and correct. If there are any changes in child's information and/or health status, I will inform the doctor as soon as reasonably possible and without fail. I understand that this information will remain confidential.

Signature of Parent/Guardian: _____ Date: _____

Signature of Doctor:_____Date _____

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General Consent

I hereby give my consent to Carolyn Lubrano, DMD, MPH and Staff to treat my child which may include the following dental procedures:

Complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), study models, photographs, and other diagnostic aids deemed necessary by Dr. Lubrano to make a thorough diagnosis of my child's dental needs.

I authorize Dr. Lubrano to provide any information to other Doctors (Physicians, Dentists, etc.) for the purpose of consultation. I understand that prior to providing any treatment I will be advised about such treatment by Dr. Lubrano or staff member, that I may ask questions concerning the treatment, and that I may revoke this consent before treatment is provided. I understand that I may ask for a full recital of any or all risks attendant to the care of my child/the patient.

Parents/Guardians: for future appointments, if you are planning to send your child with someone other than a parent/legal guardian, please provide the following information:

Name of authorized person(s) to accompany my child for future treatment visits:

1. _____ Relationship to Child _____

2. _____ Relationship to Child _____

3. _____ Relationship to Child _____

4. _____ Relationship to Child _____

Parent's Signature _____ Date _____

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HIPAA Consent Form

I consent that Milestones Pediatric Dentistry, may use and disclose my child's protected health information in order to carry out treatment, payment and healthcare operations. I have had an opportunity to read this office "Notice of Privacy Practices" and understand this policy. I also give permission for this practice to call my home (or other designated location of record) and leave messages on an answering machine or in person in reference to any items that assist in facilitating treatment, payment and healthcare operations. I will also allow this practice to mail to my home (or other designated location of record) any items that assist this practice in treatment, payment and health operations (including, but not limited to, appointment cards, statements, etc). I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon this current consent. If I do not sign this document, Milestones Pediatric Dentistry may decline to treat my child/children.

BY SIGNING BELOW, I UNDERSTAND AND AGREE TO THIS POLICY.

Child's Full Name: _____

Date of Birth: _____/_____/ _____

Parent / Guardian's Name:_____

Relationship to child:_____

Parent / Guardian's Signature: _____

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Financial Policy

We are delighted to welcome your child to our practice and we are pleased that you have chosen us to serve your child's dental needs. The following is a statement of our financial policy which we require you to read and sign at the bottom of this page.

PAYMENT IS EXPECTED AT THE TIME THAT SERVICES ARE RENDERED AND IS THE RESPONSIBILITY OF THE ACCOMPANYING ADULT.

Payment methods: we accept all major credit cards, personal checks*, cash.

*All returned checks are subject to a twenty-five dollar ($25.00) service charge.

Dental Insurance

We are pleased to participate with several insurance providers directly – please verify with our staff if you are not sure if your insurance provider is included. What your insurance doesn't pay is the patient/parent's responsibility.

An estimated co-payment is requested from you at each appointment as service is rendered. This is determined by your benefits within your plan, not our office.

Please understand that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles their claims or for what benefits they allow on a claim. We can only assist you in estimating your portion of the fees. We cannot guarantee what your insurance will pay for each claim nor can we assume responsibility for the accuracy of any insurance information. It is your responsibility to understand your insurance policy and terms.

You are responsible for payment of any balance due not paid by your insurance company, including unpaid deductible amounts. Although we try our best to estimate as accurately as possible, the final amount your insurance will actually pay isn't determined until they issue a claim check to us.

Missed appointments

We ask for your utmost courtesy regarding your scheduled appointments. If you are unable to keep your child's appointment please allow at least 24 hours prior to the appointment time if you must cancel or reschedule. We understand that unforeseen emergencies do occur, however, we reserve the right to charge a $25.00 fee for repeated last minute cancellations and broken appointments.

BY SIGNING BELOW, I UNDERSTAND AND AGREE TO THIS POLICY.

Parent's Signature _____ Date _____

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